NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS,
AND CERTIFIED NURSE MIDWIVES
STATE/COMMUNITY MATCHING
LOAN REPAYMENT PROGRAM APPLICATION

ND Department of Health
Division of Health Facilities
SFN 50556 (8-2001)

Dept. Use Only

File Number:

Telephone: 701.328.2894

Name of Health Professional				
Home Address	City	State	Zip Code	Home Phone
Office Address	City	State	Zip Code	Office Phone
Social Security Number	I prefer to be contacted at ☐ Home ☐ Office ☐ Either			

Identify your specialty

_____ Nurse Practitioner _____ Physician Assistant _____ Certified Nurse Midwife

Education for Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife

Name of School	City, State	Degree/Certificate	Graduation Year

Certification Status

☐ National Nursing Certification

Date of Initial Certification _____

Date of Certification Renewal_____

☐ Other _____

Date of Initial Certification _____

Date of Certification Renewal _____

☐ National Physician Assistant Certification

Date of Initial Certification _____

Date of Certification Renewal _____

State Licenses/Registration State	Year	License Number

OUTSTANDING EDUCATION LOANS

Lender/Address	Loan #	Amount	Balance	Date Loan Must Be Paid

Are you in default on any loans? If yes, identify loan and amount.

How much money are you requesting? (You may request no more than $10,000)

Name of North Dakota community where you will practice	Date you will be able to begin

Are you currently in litigation? If yes, please explain.

EMPLOYMENT HISTORY (List most recent employer first)

Employer	Address	Dates Employed

1. Attach three letters of recommendation.
2. Attach a copy of your North Dakota license/certification/temporary permit to practice.
3. Attach a letter of support from the community you would like to serve.
4. Include the attached Community Participation Form (SFN 50558) signed by a community representative stating the community will pay fifty percent of your loan repayment amount in exchange for 2 (two) years of full-time medical services.

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a state/community matching Health Professional loan repayment subject to the provisions of North Dakota Century Code Chapter 43-12.2 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health.

_____ _____
Signature Date

State of _____)
) ss
County of _____)

On this _____ day of _____, year _____, before me personally appeared _____ who having been sworn states that to the best of his/her knowledge and belief the statements in the foregoing application are true.

_____
Notary Public

(Seal)

My commission expires _____

Return the completed application to:

Mary Amundson
Department of Community Medicine
University of North Dakota
501 North Columbia Road
P.O. Box 9037
Grand Forks, ND 58202-9037